STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155072	A. BUILDING 00 B. WING	08/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEECH GROVE MEADOWS	2002 ALBANY ST BEECH GROVE, IN 46107

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: August 17, 18, 19, 20, 21, 22, 23, 25, 26, and 27, 2014 Facility number: 000029 Provider number: 155072 AIM number: 100275200 Survey team: Karyn Homan, RN-TC Marsha Smith, RN Dorothy Plummer, RN (8/17, 8/18, 8/19, 8/20, 8/21, 8/22, 8/23, 8/25, and 8/26, 2014) Patsy Allen, SW (8/17, 8/18, 8/19, 8/20, 8/21, 8/22, 8/23, and 8/27, 2014) Census bed type: SNF: 9 SNF/NF: 104 Residential: 14 Total: 127 Census payor type: Medicare: 11 Medicaid: 88 Other: 14	F000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Total: 113 Residential sample: 7 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 08, 2014; by Kimberly Perigo, RN.			
F000241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, record review, and interview, the facility failed to ensure an incontinent resident's dignity was maintained for 1 random observation of urinary incontinence. (Resident #67) Findings include: The clinical record of Resident #67 was reviewed on 8/21/14 at 1:30 p.m. Her diagnoses included, but were not limited to, dementia and urinary retention.	F000241	1.Resident #67 was immediately assisted withpersonal care once incontinence was identified. 2.All residents have the potential to beaffected. All residents withincontinence were checked for needed assistance with personal care by DNS /Designee. Those requiring assistancewere provided it immediately. 3.All staff will be in-serviced regarding residentdignity and incontinence management by the Staff Development Coordinator /Designee. Resident Observation form willbe Completed on each	09/26/2014

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	An annual Minimum Data Set assessment, dated 6/16/14, indicated Resident #67 was severely cognitively impaired, always incontinent, and needed extensive assistance of 2 or more staff to use the bathroom. During a random observation, near the nurses' station, on 8/21/14 from 3:25 p.m. to 3:35 p.m., Resident #67 was observed sitting in a wheelchair outside of her room. A pool of liquid was observed directly under the seat of her wheelchair. Various staff members walked past the resident during that time. Certified Nursing Assistant (CNA) #4 was asked about the liquid at 3:35 p.m. He immediately placed a white towel on top of the liquid and took Resident #67 into her room. When the liquid on the floor soaked into the towel, the towel appeared yellow. At 3:40 p.m., the Unit Manager indicated the resident had been incontinent. At 3:45 p.m., CNA #4 indicated the resident had been incontinent while sitting in the hallway in her wheelchair. On 8/22/14 at 11:45 a.m., the Director of Nursing provided a policy dated 1/2006, titled, "Resident Rights," and indicated the policy was the one currently used by the facility. The policy indicated, "All staff members recognize the rights of		shift by the DNS / Designee and be utilized to assurepersonal care needs are promptly addressed. Resident care plans will be reviewed for accuracy and resident profileswill be updated to accurately reflect the residents needs. 4.Resident dignity and incontinence managementwill be monitored utilizing the Accommodation of Needs CQI daily duringCustomer Care Rounds by the Customer Care Representatives or theirdesignee. Results of the Accommodationof needs CQI will be reviewed at Quality Assurance meeting monthly for 6consecutive months at 90% proficiency then quarterly thereafter to 2consecutive quarters. Issues identifiedwith Resident Dignity or incontinence management will be addressed by theQuality Assurance committee via corrective action plan.	

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	residents at all times and residents assume their responsibilities to enable personal dignity, well being, and proper delivery of care...." 3.1-3(t)			
F000282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview, and record review, the facility failed to ensure residents written plans of care were followed for 7 of 21 residents in that sliding scale insulin was not documented as administered as ordered by the physician (Resident #70 and Resident #139), blood glucose monitoring was not completed (Resident #139, Resident #26, and Resident #67), vital signs were not completed as ordered by the physician (Resident #11 and Resident #69), physician notification of weight loss was not completed (Resident #123), and monitoring for abnormal involuntary movements (AIMS) was not completed as indicated. (Resident #11, Resident #70, and Resident #139)	F000282	1.Licensed staff were immediately in-serviced ondocumenting the administration of sliding scale insulin for residents #70 and#139. Resident #70 and #139 arereceiving sliding scale insulin per physicians orders. Licensed staff were immediately in-servicedon completing and documenting blood glucose monitoring for residents #139, #26,and #67. Care plans were reviewed forresidents #139, #26, and #67 to ensure accuracy regarding diabetesmellitus. Residents #139, #26, and #67are receiving blood glucose monitoring per physicians orders. Licensed staff were immediately in-servicedon completing and documenting vital signs for residents #11 and #69.	09/26/2014

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	Findings include: 1a. The clinical record of Resident #70 was reviewed on 8/19/14 at 5:15 p.m. Diagnoses included, but were not limited to, diabetes. Resident #70 had a plan of care dated 1/1/12, indicating the resident was at risk for adverse effects of high or low blood sugars related to use of glucose lowering medication and/or diagnosis of diabetes mellitus. Interventions included, but were not limited to, "blood sugars as ordered and medications as ordered." A review of the recapitulation of physician's orders for August 2014, indicated Resident #70 was ordered insulin aspart (NovoLog, a short acting insulin) on a sliding scale dose twice a day with a start date of 7/15/12. The sliding scale dose was based on the results of blood glucose monitoring and included blood glucose results of 200 - 250 = 2 units, 251 - 300 = 4 units, 301 - 350 = 6 units, 351 - 400 = 8 units, greater than 400 = 10 units, and call for blood sugars less than 70 or greater than 500. A review of the Capillary Blood Glucose Monitoring Tool for July 2014, indicated Resident #70 was not administered		Vital signs are being checked per physiciansorders for residents #11 and #69. Licensed staff were immediately in-serviced on reporting weight loss forresident #123. Weights and physician notification are taking place perphysicians orders for resident #123. Licensed staff were immediatelyin-serviced on the completion of AIMS for residents #11, #70, and #139. Residents #11, #70, #139 had AIMS completedby DNS / Designee on 9/2/14. 2.All resident on Metoclopram, requiringaccuchecks, requiring Weight Management, or receiving Dialysis have thepotential to be affected by this practice. Licensed staff were immediately in-serviced on documenting theadministration of sliding scale insulin by the Staff Development Coordinator /Designee. An audit was completed by theDNS / Designee to ensure that residents with sliding scale insulins werereceiving insulin as ordered. Licensed staff were immediately in-serviced oncompleting and documenting blood glucose monitoring. An audit was completed by the DNS / Designeeto ensure that residents with sliding scale insulins were receiving insulin asordered. Licensed staff were immediately in-serviced staff were immediatelyin-serviced on completing and documenting vital signs. An audit was completed	

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	sliding scale insulin as ordered. On 7/3/14 at 6:00 a.m., a blood glucose of 230 was recorded. As indicated by the sliding scale order the resident should have received 2 units of NovoLog sliding scale insulin. No sliding scale insulin was documented as given. On 7/4/14 at 6:00 a.m., a blood glucose of 308 was recorded. As indicated by the sliding scale order the resident should have received 6 units of NovoLog sliding scale insulin. No sliding scale insulin was documented as given. On 7/8/14 at 6:00 a.m., a blood glucose of 313 was recorded. As indicated by the sliding scale order the resident should have received 6 units of NovoLog sliding scale insulin. No sliding scale insulin was documented as given. On 7/9/14 at 4:00 p.m., a blood glucose of 376 was recorded. As indicated by the sliding scale order the resident should have received 8 units of NovoLog sliding scale insulin. No sliding scale insulin was documented as given. On 7/11/14 at 4:00 p.m., a blood glucose of 362 was recorded. As indicated by the sliding scale order the resident should have received 8 units of NovoLog sliding		by the DNS / Designeeto ensure that residents vital signs were documented as ordered. Licensed staffwere immediately in-serviced on reporting weight loss. An Audit was completed by the DNS / Designeeto ensure all weight loss notifications are communicated with the attendingphysician. Licensed staff wereimmediately in-serviced on the completion of AIMS for residents receiving themedications Metoclopram and Compazine. An audit was completed by the DNS / Designee to ensure that allresidents on medications requiring AIMS assessments were completed. 3.Licensed staff will receive in-service trainingregarding Diabetes Management via ASC policy, including completing accuchecksassessment post fall when appropriate, following the physicians orders, and theappropriate documentation on the Blood Glucose Monitoring Flow Sheet. Diabetes Management including following thephysicians orders and the appropriate documentation on the Blood GlucoseMonitoring Flow Sheet will be monitored daily via audits of the MAR and FlowSheets by the Director of Nursing / Designee. Licensed staff will receive in-service training regarding monitoringVital Signs including following the physicians orders and appropriatedocumentation of vital	

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	scale insulin. No sliding scale insulin was documented as given. On 7/12/14 at 6:00 a.m., a blood glucose of 271 was recorded. As indicated by the sliding scale order the resident should have received 4 units of NovoLog sliding scale insulin. No sliding scale insulin was documented as given. On 7/12/14 at 4:00 p.m., a blood glucose of 320 was recorded. As indicated by the sliding scale order the resident should have received 6 units of NovoLog sliding scale insulin. No sliding scale insulin was documented as given. On 7/13/14 at 6:00 a.m., a blood glucose of 308 was recorded. As indicated by the sliding scale order the resident should have received 6 units of NovoLog sliding scale insulin. No sliding scale insulin was documented as given. On 7/13/14 at 4:00 p.m., a blood glucose of 201 was recorded. As indicated by the sliding scale order the resident should have received 2 units of NovoLog sliding scale insulin. No sliding scale insulin was documented as given. On 7/14/14 at 6:00 a.m., a blood glucose of 277 was recorded. As indicated by the sliding scale order the resident should		signs. VitalSigns Monitoring including following the physicians orders and the appropriatedocumentation within the MAR will be monitored daily via audits of the MAR byDirector of Nursing / Designee. Licensedstaff will receive in-service training regarding Weight Management includingthe notification of physician for significant weight loss per ASC policy. DNS / Designee will conduct MAR audits toensure weights are obtained and documented and to ensure physician is notified of any weight change per physicians order. Licensed staff will be provided in-service training regarding the needfor AIMS on all residents taking Metoclopram (Reglan), and Compazine, just asthey would any anti-psychotic medication. DNS / Designee will ensure that residents on medications requiringmonitoring by AIMS assessment will be obtained by ASC policy of every 6 months. DNS/Designee will ensure plans of care arefollowed regarding sliding scale insulin, blood glucose monitoring, vital signstaken, notification of weight loss, monitoring of involuntary movements byreviewing the facility activity report - which is a report that monitorsdaily charting of significant events and by conducting rounds each shift dailyto ensure care plans are followed	

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	have received 4 units of NovoLog sliding scale insulin. No sliding scale insulin was documented as given. On 7/16/14 at 6:00 a.m., a blood glucose of 236 was recorded. As indicated by the sliding scale order the resident should have received 2 units of NovoLog sliding scale insulin. No sliding scale insulin was documented as given. On 7/18/14 at 6:00 a.m., a blood glucose of 333 was recorded. As indicated by the sliding scale order the resident should have received 6 units of NovoLog sliding scale insulin. No sliding scale insulin was documented as given. On 7/20/14 at 6:00 a.m., a blood glucose of 251 was recorded. As indicated by the sliding scale order the resident should have received 4 units of NovoLog sliding scale insulin. No sliding scale insulin was documented as given. On 7/21/14 at 6:00 a.m., a blood glucose of 243 was recorded. As indicated by the sliding scale order the resident should have received 2 units of NovoLog sliding scale insulin. No sliding scale insulin was documented as given. On 7/26/14 at 6:00 a.m., a blood glucose of 386 was recorded. As indicated by the		4. Theresults of those audits will be compiled within the Blood Glucose MonitoringCQI monthly at the Quality Assurance Meeting for 6 consecutive months with 95%proficiency then quarterly thereafter for 2 consecutive quarters. Vital Signs Monitoring including followingthe physicians orders and the appropriate documentation within the MAR will bemonitored daily via audits of the MAR by Director of Nursing / Designee. The results of those audits will be compiled monthlyfor inclusion in the Quality Assurance Meeting for 6 consecutive months with95% proficiency then quarterly thereafter for 2 consecutive quarters. Weight Management, including the notificationof physician for significant weight changes, will be monitored via the ResidentWeights CQI monthly for 6 consecutive months with 95% proficiency thenquarterly thereafter for 2 consecutive quarters. Completion of AIMS for appropriatemedications including Metoclopram and Compazine will be monitored by PsychoactiveManagement CQI tool monthly at Quality Assurance Committee meeting for 6 monthsat 100% proficiency, then quarterly thereafter for 2 consecutive quarters. Issues identified with Diabetes Management,Vital Signs, Weight Management, or AIMS completion by the Quality	

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	sliding scale order the resident should have received 8 units of NovoLog sliding scale insulin. No sliding scale insulin was documented as given. A review of the Capillary Blood Glucose Monitoring Tool for August 2014, indicated Resident #70 was not administered sliding scale insulin as ordered. On 8/1/14 at 6:00 a.m., a blood glucose of 415 was recorded. As indicated by the sliding scale order the resident should have received 10 units of NovoLog sliding scale insulin. No sliding scale insulin was documented as given. On 8/6/14 at 6:00 a.m., a blood glucose of 395 was recorded. As indicated by the sliding scale order the resident should have received 8 units of NovoLog sliding scale insulin. No sliding scale insulin was documented as given. On 8/8/14 at 6:00 a.m., a blood glucose of 255 was recorded. As indicated by the sliding scale order the resident should have received 4 units of NovoLog sliding scale insulin. No sliding scale insulin was documented as given. On 8/14/14 at 6:00 a.m., a blood glucose of 409 was recorded. As indicated by the		AssuranceCommittee will be addressed via corrective action plan.	

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	sliding scale order the resident should have received 10 units of NovoLog sliding scale insulin. No sliding scale insulin was documented as given. 1b. The clinical record of Resident #139 was reviewed on 8/20/14 at 2:53 p.m. Diagnoses included, but were not limited to, diabetes. Resident #139 had a plan of care dated 2/24/14, indicating the resident was at risk for adverse effects of high or low blood sugars related to use of glucose lowering medication and/or diagnosis of diabetes mellitus. Interventions included, but were not limited to, "blood sugars as ordered and medications as ordered." A review of the recapitulation of physician's orders for August 2013, indicated Resident #139 was ordered insulin lispro (Humalog, a short acting insulin) on a sliding scale dose with meals and at bedtime with a start date of 3/27/14. The sliding scale dose was based on the results of blood glucose (blood sugar) monitoring, also ordered to be completed with meals and at bedtime. The sliding scale insulin dosage with meals included 151 - 200 = 1 units, 201 - 250 = 2 units, 251 - 300 = 3 units, 301 - 350 = 4 units, greater than 351 = 5 units, and call for blood sugars less than 70 or			

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	greater than 351. The sliding scale dosage at bedtime included 201 - 300 = 1 unit, 301 - 400 = 2 units, greater than 401 = 3 units, and call for blood sugars less than 70 or greater than 401. A review of the Capillary Blood Glucose Monitoring Tool for August 2014, indicated Resident #139 was not administered sliding scale insulin as ordered. On 8/1/14 at 6:00 a.m., a blood glucose of 279 was recorded. As indicated by the sliding scale order the resident should have received 3 units of Humalog sliding scale insulin. No sliding scale insulin was documented as given. At 11:00 a.m., on 8/1/14, the resident had a blood glucose of 186 and should have received 1 unit of sliding scale insulin. No sliding scale insulin was documented as given. On 8/2/14 at 9:00 p.m., the resident had a blood glucose of 348 and should have received 4 units of sliding scale insulin. The resident received 2 units of Humalog insulin. On 8/3/14 at 9:00 p.m., the resident had a blood glucose of 392 and should have received 5 units of sliding scale insulin.			

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	The documentation indicated Resident #139 received 2 units of sliding scale Humalog. On 8/4/14 at 11:00 a.m., the resident had a blood glucose of 184 and should have received 1 unit of sliding scale insulin. No sliding scale insulin was documented as given. At 9:00 p.m. on 8/4/14, the resident had a blood glucose of 340 and should have received 4 units of sliding scale insulin. No sliding scale insulin was documented as given. On 8/6/14 at 6:00 a.m., the resident had a blood glucose of 154 and should have received 1 unit of sliding scale insulin. No sliding scale insulin was documented as given. The blood glucose for 8/6/14 at 11:00 a.m., was documented as 353. The resident should have received 5 units of sliding scale insulin. The sliding scale insulin was documented as 8 units administered. The blood glucose for 8/7/14 at 11:00 a.m., was documented as 497. The resident should have received 5 units of sliding scale insulin. The sliding scale insulin was documented as 8 units administered. The blood glucose for 8/8/14 at 6:00 a.m., was documented as 321. The			

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	resident should have received 4 units of sliding scale insulin. No sliding scale insulin was documented as given. The blood glucose for 8/9/14 at 6:00 a.m., was documented as 209. The resident should have received 2 units of sliding scale insulin. No sliding scale insulin was documented as given. The documentation lacked a blood glucose and sliding scale insulin administration for 8/9/14 at 11:00 a.m. The blood glucose for 8/9/14 at 9:00 p.m., was documented as 400. The resident should have received 2 units of sliding scale insulin. No sliding scale insulin was documented as given. The blood glucose for 8/10/14 at 11:00 a.m., was documented as 174. The resident should have received 1 unit of sliding scale insulin. No sliding scale insulin was documented as given. The documentation lacked a blood glucose and sliding scale insulin administration for 8/11/14 at 11:00 a.m. The blood glucose for 8/12/14 at 11:00 a.m., was documented as 164. The resident should have received 1 unit of sliding scale insulin. No sliding scale insulin was documented as given.			

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The blood glucose for 8/13/14 at 6:00 a.m., was documented as 192. The resident should have received 1 unit of sliding scale insulin. No sliding scale insulin was documented as given.

The documentation lacked a blood glucose and sliding scale insulin administration for 8/13/14 at 11:00 a.m.

The blood glucose for 8/14/14 at 11:00 a.m., was documented as 176. The resident should have received 1 unit of sliding scale insulin. No sliding scale insulin was documented as given.

The blood glucose for 8/14/14 at 9:00 p.m., was documented as 347. The resident should have received 2 units of sliding scale insulin. The documentation indicated the resident received 4 units of sliding scale insulin.

The blood glucose for 8/15/14 at 6:00 a.m., was documented as 152. The resident should have received 1 unit of sliding scale insulin. No sliding scale insulin was documented as given.

The blood glucose for 8/16/14 at 6:00 a.m., was documented as 158. The resident should have received 1 unit of sliding scale insulin. No sliding scale

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	insulin was documented as given. The blood glucose for 8/16/14 at 11:00 a.m., was documented as 315. The resident should have received 4 units of sliding scale insulin. No sliding scale insulin was documented as given. The blood glucose for 8/17/14 at 6:00 a.m., was documented as 262. The resident should have received 3 units of sliding scale insulin. The documentation indicated the resident was administered 2 units of sliding scale insulin. During an interview with Licensed Practical Nurse (LPN) #5 on 8/19/14 at 2:10 p.m., LPN #5 indicated the results of the blood sugars were documented on the blood sugar flowsheet and then in the column next to the blood sugar the amount of sliding scale insulin administered should be documented. LPN #5 indicated the flowsheet was the only place the sliding scale insulin administration was documented. 2a. The clinical record of Resident #139 was reviewed on 8/20/14 at 2:53 p.m. Diagnoses included, but were not limited to, diabetes. Resident #139 had a plan of care dated 2/24/14, indicating the resident was at			

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	risk for adverse effects of high or low blood sugars related to use of glucose lowering medication and/or diagnosis of diabetes mellitus. Interventions included, but were not limited to, "blood sugars as ordered, labs as ordered, and medications as ordered." On 3/27/14, Resident #139 was ordered insulin lispro (Humalog, a short acting insulin) on a sliding scale dose with meals and at bedtime. The sliding scale dose was based on the results of blood glucose (blood sugar) monitoring, also ordered to be completed with meals and at bedtime. A review of the Capillary Blood Glucose Monitoring Tool for Resident #139 for the month of July 2014, indicated the facility failed to check a blood glucose on 7/1/14 at 11:00 a.m.; 7/3/14 at 9:00 p.m.; 7/7/14 at 11:00 a.m.; on 7/8/14 at 11:00 a.m., 4:00 p.m., and 9:00 p.m.; on 7/10/14 at 11:00 a.m.; 7/12/14 at 6:00 a.m., 4:00 p.m., and 9:00 p.m.; 7/20/14 at 11:00 a.m.; 7/22/14 at 11:00 a.m.; 7/29/14 11:00 a.m.; and on 7/31/14 at 11:00 a.m. and 9:00 p.m. A review of the Capillary Blood Glucose Monitoring Tool for Resident #139 for the month of August 2014, indicated the facility failed to check a blood glucose on			

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	8/9/14 at 11:00 a.m.; 8/11/14 at 11:00 a.m.; and 8/13/14 at 11:00 a.m. During an interview with Licensed Practical Nurse (LPN) #5 on 8/19/14 at 2:10 p.m., LPN #5 indicated the results of the blood sugars were documented on the blood sugar flowsheet (Capillary Blood Glucose Monitoring Tool) and then in the column next to the blood sugar the amount of sliding scale insulin administered should be documented. LPN #5 indicated the flowsheet was the only place the glucose monitoring was documented. During an interview with the Director of Nursing (DON) on 8/21/14 at 3:30 p.m., the DON indicated the blood glucose monitoring was individualized to each resident and the expectation was that the blood sugar monitoring would be completed as ordered by the physician. 2b. The clinical record of Resident #26 was reviewed on 8/20/14 at 12:55 a.m. Diagnoses included, but were not limited to, diabetes mellitus. Diabetes mellitus is a condition in which the body is unable to efficiently move sugar from the bloodstream into cells. Symptoms of high or low blood sugar include fatigue, blurred vision, feeling			

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	shaky, dizziness,weakness, and difficulty thinking. A care plan, dated 7/16/14 through 10/16/14, indicated Resident #26 was, "... at risk for falls due to...DM [diabetes mellitus]...." A care plan dated 7/16/14 through 10/16/14, indicated Resident #26 was at risk for adverse effects of high or low blood sugars related to use of glucose lowering medication and/or diagnosis of diabetes mellitus. A Progress Note, dated 8/5/14 at 9:24 a.m., indicated, "...team met to review assisted fall occurring 8/4/14 at 10:48 p.m.. ..Res[ident] is not diabetic..." Review of a fall event dated 8/4/14, indicated Resident #26 was sitting on her bottom on the bathroom floor. This had occurred during an assisted transfer from her wheelchair to the toilet. The fall event indicated the resident was not diabetic and an accucheck (a finger stick blood test to measure blood sugar) was not done. 2c. The clinical record of Resident #67 was reviewed on 8/21/14 at 1:30 p.m. Diagnoses included, but were not limited to, diabetes mellitus and vertigo			

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	(dizziness). A care plan for Resident #67, dated 4/12/12 through 10/1/14, indicated she had the potential for high or low blood sugar reactions. A care plan for Resident #67, dated 4/12/12 through 10/1/14, indicated she was a fall risk. Review of a fall event for Resident #67, dated 8/10/14, indicated on 8/9/14 at 10:45 p.m., she was found lying on the floor mat next to her bed. The fall event indicated she was not a diabetic and her accucheck was not done. Review of a progress note dated 8/11/14 at 2:06 p.m., indicated "...team met to review unwitnessed fall occurring 8/9/14 at 10:45 p.m....Res[ident] is not diabetic...." Review of a fall event for Resident #67 dated 8/16/14, indicated resident was found sitting on floor by the side of the bed. The fall event indicated she was not a diabetic and an accucheck was not performed. Review of a progress note dated 8/19/14 at 9:32 a.m., indicated, "...team met to review unwitnessed fall occurring			

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	8/16/14 at 4:00 p.m...res[ident] was found sitting on the floor next to her bed...after a full assessment res[ident] was assisted to WC [wheelchair]...." On 8/20/14 at 2:20 p.m., the Director of Nursing provided a policy dated 9/2013, titled, "Fall Management Program," and indicated the policy was the current policy used by the facility. The policy indicated, "...A fall event will be initiated as soon as the resident has been assessed and cared for. The report must be completed in full in order to identify possible root causes of the fall and provide immediate interventions...." One of the questions on the fall event was whether or not the resident was diabetic and if so, the results of an accucheck performed after the fall. 3a. The clinical record of Resident #11 was reviewed on 8/21/14 at 4:04 p.m. Diagnoses included, but were not limited to, hypertension (high blood pressure). A review of the recapitulation of physician's orders for August 2014, indicated Resident #11 was to have vital signs taken daily and recorded. The origination date of the order was 7/29/13. A review of the Medication Administration Record (MAR) for June			

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	2014 and July 2014, indicated the vital signs should have been completed on days (6:00 a.m. to 2:00 p.m.) and should have been recorded in "Matrix." The MARs also indicated, "D/C'd (discontinued)" in large letters over and beside the order to complete the vitals signs. No vital signs were recorded on the MARs. During an interview with the Director of Nursing (DON) 8/21/14 at 5:35 p.m., the DON indicated the facility did not have a specific policy for taking and recording vital signs. During an interview with the DON on 8/22/14 at 11:45 a.m., the DON provided vital signs documented as completed in Matrix 2 times in June 2014, 2 times in July 2014, and none for August 2014. The DON indicated those were the only results available for Resident #11. 3b. Resident #69's clinical record was reviewed on 8/20/14 at 9:10 a.m. Diagnoses included, but were not limited to, hypertension (high blood pressure). Recapulated Physician orders dated August 2014, indicated, "Take BP [blood pressure] once daily in the morning weekly on Tuesdays and record VS [vital signs] in Matrix System [electronic charting]." The recapulated order			

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	indicated the original order date was 8/15/2012. No blood pressures were found in Resident #69's chart documented on the following dates: 11/19/13 2/25/14 4/29/14 5/6/14 5/20/14 6/3/14 6/10/14 6/17/14 6/24/14 7/1/14 7/8/14 7/15/14 7/22/14 7/29/14 8/5/14 8/12/14 8/19/14 On 8/20/14 at 2:10 p.m., the Director of Nursing (DON) indicated they were unable to locate documented blood pressures for the questioned dates. The facility believed the physician had come in around mid May 2014, and discontinued the blood pressure order, due to Resident #69 refusing blood pressures. No order indicating the blood pressures were discontinued was found			

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	nor any documentation indicating Resident #69 refused the blood pressures was found. Care Plan initiated 9/30/11, indicated, "Problem ... Resident is at risk for hypo/hypertension ... Approach ... Observe for and document: ...variations in B/P [blood pressure]...." 4. Resident #123's clinical record was reviewed on 8/20/14 at 10:53 a.m. Diagnoses included, but were not limited to, congestive heart failure (condition where the heart is unable to pump enough blood to the rest of the body) and hypertension (high blood pressure). Physician order dated 5/21/14, indicated, "... Daily wt [weight] notify IHP [Indiana Heart Physicians] for wt [weight] loss or gain of 3 lbs [pounds] in a day or 5 lbs in a week...." Daily weight sheets indicated a weight loss of three or more pounds (lbs) on the following dates: 5/29/14 weight 200 lbs, 10 lb weight loss from 5/28/14 6/2/14 weight 194 lbs, 5 lb weight loss from 6/1/14 6/5/14 weight 190 lbs, 3 lb weight loss from 6/4/14 6/9/14 weight 186 lbs, 4 lb weight loss			

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	from 6/8/14 6/10/14 weight 183 lbs, 3 lb weight loss from 6/9/14 On 8/21/14 at 4:45 p.m., the Director of Nursing indicated, the facility was unable to locate any documentation indicating the physician was notified of these weight loses. 5a. The clinical record of Resident #70 was reviewed on 8/19/14 at 5:15 p.m. Diagnoses included, but were not limited to, depressive disorder, renal (kidney) failure, liver disorder, and gastroesophageal reflux (a condition in which the stomach contents leak backwards into the tube between the stomach and the mouth). A review of the recapitulation of physician's orders for August 2014, indicated Resident #70 was ordered metoclopram 5 mg (milligrams) (adverse reactions: ...extrapyramidal symptoms ... tardive dyskinesia/uncontrolled or involuntary movements) 3 times a day before meals as an appetite stimulant. The origination date of the metoclopram was 6/8/13. A review of the Medication Administration Record (MAR) for August 2014, indicated Resident #70			

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	was administered metoclopram (Reglan) daily 3 times a day. A review of observation reports completed for Resident #70 indicated an Abnormal Involuntary Movement Scale (AIMS/an assessment to evaluate for extrapyramidal symptoms and/or tardive dyskinesia) was completed 11/5/13. During an interview with the Director of Nursing (DON) on 8/22/14 at 10:30 a.m., the DON indicated the AIMS completed 11/5/13, was the most recent one for Resident #70. 5b. The clinical record of Resident #139 was reviewed on 8/20/14 at 2:53 p.m. Diagnoses included, but were not limited to gastroparesis (a condition that occurs when the stomach takes too long to empty). A review of the recapitulation of physician's orders for August 2014, indicated Resident #139 was ordered metoclopram (Reglan) 10 mg (milligrams) (adverse reactions: ...extrapyramidal symptoms ... tardive dyskinesia/uncontrolled or involuntary movements) 3 times a day for gastroparesis. The origination date of the metoclopram was 4/19/14.			

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	A review of the Medication Administration Record (MAR) for August 2014, indicated Resident #139 was administered metoclopram daily 3 times a day. During a review of observation reports completed for Resident #139 no Abnormal Involuntary Movement Scale (AIMS/an assessment to evaluate for extrapyramidal symptoms and/or tardive dyskinesia) were found. During an interview with the Director of Nursing (DON) on 8/22/14 at 10:30 a.m., the DON indicated no AIMS had been completed for Resident #139. 5c. The clinical record of Resident #11 was reviewed on 8/21/14 at 4:04 p.m. Diagnoses included, but were not limited to, restless leg syndrome, obsessive compulsive disorder, anxiety, depression, diabetes, and gastroparesis (a condition that occurs when the stomach takes too long to empty). A review of the recapitulation of physician's orders for August 2014, indicated Resident #11 was ordered metoclopram (Reglan) (adverse reactions: ...extrapyramidal symptoms ... tardive dyskinesia/uncontrolled or involuntary movements) 10 mg 4 times a day for			

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	diabetes. A review of the Medication Administration Record (MAR) for August 2014, indicated Resident #11 was administered metoclopram daily 4 times a day. During a review of observation reports completed for Resident #11 no Abnormal Involuntary Movement Scale (AIMS/an assessment to evaluate for extrapyramidal symptoms and/or tardive dyskinesia) were found. During an interview with the Director of Nursing (DON) on 8/21/14 at 3:30 p.m., the DON indicated Resident #11 was receiving Reglan and should have had an AIMS completed, but no AIMS had been completed for Resident #11. The DON provided the "Documentation Guidelines for Nursing" dated 6/2014, and indicated the policy was the one currently used by the facility. The policy indicated, "...Assessments completed - Other...AIMS - every 6 months for residents receiving antipsychotics or Reglan [metoclopram]...." The Nursing Drug Handbook, 34th edition, copy right 2014, indicated residents receiving metoclopram should			

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	be assessed and monitored for involuntary movements. 3.1-35(g)(2)			
F000309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on interview and record review, the facility failed to provide the necessary services in accordance with the plan of care for a resident receiving dialysis as evidenced by failure to restrict fluids to 1500 ml (milliliters) each day and failure to observe the dialysis site on a daily basis. (Resident #139) Findings include: 1. The clinical record of Resident #139 was reviewed on 8/20/14 at 2:53 p.m. Diagnoses included, but were not limited to, diabetes and end stage renal disease requiring dialysis 3 times a week. A Significant Change Minimum Data Set (MDS) assessment completed 6/14/14, assessed Resident #139 as having end	F000309	1.Fluid intake for resident #139 was immediatelyreviewed and adjusted accordingly. Resident #139's dialysissite was immediately checked by RN and assured within normal limits. 2.All residents on Fluid restriction have thepotential to be affected. Fluid intake for all residents with a fluidrestriction was immediately reviewed and adjusted accordingly. The dialysis sites for all residents ondialysis were checked by RN and assured within normal limits. 3.Licensed personnel will be in-serviced on theproper calculation of the fluid restriction including the fluids associatedwith medication administration by Staff Development Coordinator /Designee. Physician will be notifiedadjustments of scheduled fluids will be made if necessary to	09/26/2014

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	stage renal disease and received dialysis 3 times a week. A Brief Interview for Mental Status (BIMS) assessed the resident as having mild cognitive impairment with a score of 12. The resident was assessed as requiring extensive assistance of 1 staff person for eating and personal hygiene. Resident #139 had a plan of care dated 2/24/14, which indicated the resident was at risk for fluid imbalance due to diuretic medication, assistance with food and fluids, and had a fluid restriction of 1500 ml. Interventions included, but were not limited to, no water pitcher in room, record intake, encourage fluids, and fluid restriction of dietary to provide 360 ml with breakfast, 480 ml with lunch and dinner, and nursing to provide 180 ml on days and evenings and 60 ml for night shift for a total of 1740 each day. A review of the recapitulation of physician's orders for August 2014, indicated the resident had a fluid restriction of 1500 ml per day. The origination date of the fluid restriction was 4/5/14. The division of fluids indicated the resident had 60 ml for night shift and 180 ml for days and evenings for medication administration. The division of fluids for meals indicated the resident was allowed 360 ml with		assure maintenanceat limit. Licensed personnel will bein-serviced on post-dialysis protocols including following the physiciansorders for dialysis site assessment by the Staff Development Coordinator /Designee. Fluid restriction compliance will be reviewed daily by the RegisteredDietitian or designee through intake records and Medication AdministrationRecord. Dialysis site assessment will be completed daily through the DialysisAppointment Assessment Form by the Director of Nursing / Designee. 4.Results of that daily review will be monitoredby the fluid restriction CQI tool reviewed monthly at the Quality AssuranceCommittee meeting for 6 consecutive months at 90% proficiency then quarterlythereafter for 2 consecutive quarters. The results of those assessments will be monitored by the Dialysis CQImonthly at the Quality Assurance Committee meeting for 6 consecutive months at90% proficiency then quarterly thereafter for 2 consecutive quarters. Issues identified with fluid restrictionand/or following physicians orders for dialysis site assessment will beaddressed by the Quality Assurance Committee via corrective action plan.	

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	breakfast and 480 ml for lunch and supper for a total of 1740 ml, 240 ml over the 1500 ml restriction. A review of the Medication Administration Record (MAR) for August 2014, indicated the resident received the fluids with medication administration and received additional fluids for all three shifts as well as the fluids received with meals. During an interview with the Registered Dietician (RD) on 8/23/14 at 10:15 a.m., the RD indicated the resident was not always compliant with the fluid restriction and the facility had attempted to divide the fluids as the resident had requested. The RD indicated the facility had discovered the overage of fluids in the division for dietary and nursing and had made adjustments to plan of care. A review of the Rounding Report from the dialysis center dated 8/13/14, indicated the resident had an average weight gain of 4.4 kg (kilograms) for the month of August 2014, which indicated approximately 2 liters of fluid consumption per day. The instructions on the Rounding Report indicated the resident should have a 1200 ml fluid restriction.			

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	During an interview on 8/23/14 at 11:00 a.m., with Licensed Practical Nurse (LPN) #5 and the RD, LPN #5 and RD indicated the recommendation for the 1200 ml restriction had not been noted by nursing nor by dietary and had not been added to the plan of care for the resident. As of 8/23/14 at 1:00 p.m., the facility was unable to provide an accurate daily total fluid intake for Resident #139 for the months of April, May, June, July nor August 2014. On 8/20/14 at 5:15 p.m., the DON provided the Fluid Restriction policy dated 4/2011, and indicated the policy was the one currently used by the facility. The policy indicated, "...Residents with a physician's order for a fluid restriction will be followed by the facility and divided between Dietary and Nursing Services...." 2. The clinical record of Resident #139 was reviewed on 8/20/14 at 2:53 p.m. Diagnoses included, but were not limited to, end stage renal disease requiring dialysis 3 times a week, A Significant Change Minimum Data Set (MDS) assessment completed 6/14/14, assessed Resident #139 as having end stage renal disease and received dialysis 3			

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	times a week. A Brief Interview for Mental Status (BIMS) assessed the resident as having mild cognitive impairment with a score of 12. The resident was assessed as requiring extensive assistance of 1 staff person for eating and personal hygiene. A review of the recapitulation of physician's orders for August 2014, indicated the dialysis site should be assessed on a daily basis. A review of the MAR for July 2014, indicated the dialysis site was observed on Monday, Wednesday and Friday for the month. On 8/20/14 at 5:15 p.m., the Director of Nursing (DON) provided the Dialysis Care policy dated 9/2012, and indicated the policy was the current one used by the facility. The policy indicated, "...An assessment of the resident's dialysis site will be completed daily to include bruit and thrill (if applicable), condition of skin at site, drainage, pain, warmth, redness, and recorded as the Medication Administration Record (MAR) and/or dialysis flow sheet specific to facility policy...." 3.1-37(a)			

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F000315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on interview and record review, the facility failed to ensure necessary indications for urinary catheter use were obtained for 1 of 2 residents reviewed for urinary catheter (catheter used to drain the bladder) use. (Resident #59) Findings include: Resident #59's clinical record was reviewed on 8/22/14 at 10:21 a.m. Diagnoses included, but were not limited to, urinary retention. Resident #59 was readmitted to the facility on 7/22/14, after having abdominal surgery. Physician orders dated 7/23/14, indicated, "[manufacturer's name for an urinary catheter] catheter [urinary catheter] - add Dx [diagnosis] urinary retention."	F000315	1.Resident #59 was reviewed by Urologist 9-2-14 todetermine whether catheter use was still indicated in his plan of care. Appropriate associated diagnosis was obtainedfor continued use of catheter. 2.All residents with catheters have the potentialto be affected. All residents withcatheters will be reviewed by physician to assure continued use of catheter isindicated in their plan of care. Appropriate associated diagnoses will be ensured for each. 3.Licensed personnel will be in-serviced on theproper use of Catheters and ASC'spolicy and procedure for their use by the Staff Development Coordinator /Designee. DNS / Designee will conductchart review each morning during morning meeting to ensure residents withcatheters have been evaluated by the attending physician for continued	09/26/2014

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	Nurse Practitioner progress notes dated 7/24/14, 8/4/14, and 8/8/14, indicated Resident #59 had a indwelling catheter due to urinary retention. The progress notes did not indicate a plan for removal or to identify the issue causing Resident #59's urinary retention. Care plan initiated 7/25/14, indicated, "Problem ... Resident requires an indwelling urinary catheter R/T [related to] urinary retension [sig]." On 8/22/14 at 10:45 a.m., Unit Manager (UM) #2 indicated, Resident #59 had returned from the hospital with the urinary catheter. When Resident #59 was readmitted his physician was asked for an order to remove the catheter. The physician refused indicating the resident had the catheter for urinary retention. The physician did not give any plan to remove the catheter or to identify the cause of the urinary retention at that time. On 8/22/14 at 11:15 a.m., UM #2 indicated, she had just called Resident #59's physician after prior interview at 10:45 a.m., an order was obtained to send Resident #59 to a urologist to determine if the urinary catheter was necessary. Hospital discharge physician note dated		use. 4.Catheter use will be monitored using theCatheter CQI reviewed monthly at the Quality Assurance Committee meeting for 6consecutive months at 90% proficiency, then quarterly for 2 consecutivequarters. Issues identified withCatheter use will be addressed by the Quality Assurance Committee viacorrective action plan.	

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	7/22/14 at 11:32 a.m., indicated, "...Urinary retention after removing ___ [manufacturer's name for an urinary catheter] 7/16/14: ... re-anchored ___ [manufacturer's name for an urinary catheter] - urinary retention 7/19 [2014], ... can try wo [sig] dc [discontinue] _____ [manufacturer's name for an urinary catheter] after bladder training at ecf [extended care facility] once he is more strong and abdominal wound better." On 8/23/14 at 12:30 p.m., the Director of Nursing indicated, the facility reads discharge notes from the hospital in their inter-disciplinary team (IDT) meetings. She did not recall this statement in Resident #59's discharge note. She continued to indicate, the facility calls the Resident's physician to ask to discontinue a urinary catheter on admission, if there is not a necessary indication for the use of the catheter. An IDT Bladder Continence Review was completed on 8/13/14 at 4:40 p.m., indicated Resident #59 was, "... mentally and physically aware of the need to void and able to use a toilet, commode, urinal or bedpan." The review also indicated, Resident #59 was, "mentally and physically able to resist voiding to attempt a bladder retraining program."			

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	IDT meeting notes dated 7/31/14, 8/7/14, 8/14/14, and 8/21/14, indicated Resident #59's surgical abdominal wound was improving. 3.1-41(a)(1)			
F000322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. Based on observation, record review, and interview, the facility failed to ensure accepted methods of clinical practice were followed during the administration of medications through an enteral tube, for 1 of 1 observations. (Resident #76)	F000322	1.LPN #3 was in-serviced immediately by the ADNSon the ASC policy for g-tube utilization. 2.All residents receiving nutrition via g-tube havethe potential to be affected. All Licensed staff were in-serviced by ADNS onthe ASC policy for g-tube utilization by 9/26/14. 3.All licensed staff will receive	09/26/2014

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	Findings include: During an observation on 8/21/14 at 11:55 a.m., Licensed Practical Nurse (LPN) #1 gave medications to Resident #76 through an enteral tube (a hollow tube surgically inserted through the skin into the stomach). LPN #3 was observed inserting a small amount of air into the tube to check for the placement of the tube in the stomach and then instilling a small amount into the tube of water prior to medication administration through the tube. LPN #3 did not check for residual before she administered medication through the tube. (Residual should be checked to make sure gastric contents are being digested and not just building up in the stomach) During an interview with LPN #1 at that time, she indicated the facility policy was to check for residual every shift, not each time they gave medications. On 8/21/14 at 3:30 p.m., the Director of Nursing(DON) provided a policy dated 3/2013, titled, "Enteral Tube - Medication Administration," and indicated the policy was the one currently used by the facility. The policy indicated, "...8. check enteral tube for patency & gastric content..." At that time, the DON indicated nurses were always supposed to check for residual prior to administering		in-servicetraining via Skills Validation Checklist for skills related to g-tubemedication administration. All licensedpersonnel will complete an observed G-tube skills validation by DNS or designeeto verify training. 4.G-tube use will be monitored using the EnteralTherapy CQI, reviewed monthly at the Quality Assurance Committee meeting for 6consecutive months at 90% proficiency, then quarterly for 2 consecutivequarters. Issues identified with G-tubeuse will be addressed by the Quality Assurance Committee via corrective actionplan.	

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	medications through an enteral tube. 3.1-44(a)(2)			
F000323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure resident safety from hazardous chemicals in a soiled utility room on the E and F halls and an eye wash station on the A, B, and C halls, for 1 of 1 random observations. This had the potential to affect 16 cognitively impaired residents (Residents #69, 22, 65, 110, 139, 104, 87, 32, 99, 106, 118, 2, 126, 155, 108 and 1) on the A, B, and C halls, and 3 cognitively impaired residents (Residents #121, 26 and 133) on the E and F halls. Findings include: 1. During a random observation on 8/17/14 at 6:40 p.m. on the A, B, and C halls, the door to the soiled utility room was found to be unlocked. The following was found in the room:	F000323	1.All doors leading to areas with potentialhazards were immediately locked upon discovery. 2.All residents have the potential to beaffected. All doors leading to areaswith potential hazards were checked and immediately locked upon discovery. 3.The locking mechanism on all doors leading toareas with potential hazards were modified to prevent deactivating thenumerical keypad release. All closuremechanisms were calibrated to assure appropriate automatic closure and latchingof doors. Proper locking doors will bemonitored via Environmental Safety CQI daily completed by the Director ofMaintenance / Designee. 4.Proper locking doors will be monitored viaEnvironmental Safety CQI daily, and results	09/26/2014

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	Two 1 gallon bottles of Neutral Quat Disinfectant. The label on the bottles indicated to call poison control if ingested. If inhaled, get person to fresh air. If person not breathing, call 911 or ambulance or give artificial respiration. Two 1 gallon bottles of Neutral Floor Cleaner. The label indicated, causes eye and skin irritation. The above bottles were on a shelf approximately 5 1/2 feet high. A bucket, sitting on the floor of the room, with approximately 1/2 gallon of unknown liquid in it. This soiled utility room was located and used by all 3 halls. (A, B, C) 2. During a random observation of the eye wash station on the E and F halls on 8/17/14 at 6:55 p.m., the door was found to be unlocked. The following items were observed in the room: Approximately 2 gallons of dirty appearing liquid in a yellow bucket on the floor. A one gallon bottle of Neutral Quat Disinfectant. The label on the bottles		reviewed monthly at QualityAssurance Committee meeting for 6 consecutive months at 100% proficiency, thenquarterly for 2 consecutive quarters. Issues identified related to security of potentially hazardous materialswill be addressed by the Quality Assurance Committee via corrective actionplan.	

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	indicated to call poison control if ingested. If inhaled, get person to fresh air. If person not breathing, call 911 or ambulance or give artificial respiration. A one gallon bottle of Neutral Floor Cleaner The label indicated, causes eye and skin irritation. A one gallon bottle of Carpet Extraction Cleaner. The labels on the bottles indicated, "Danger corrosive to eyes, causes skin irritation. Harmful or fatal if swallowed." Two 1 quart bottles of Glass Plastic Cleaner. The labels on the bottles indicated, "Causes eye irritation." A large, uncovered, trash can filled with trash tied in clear plastic bags. A hopper which was discolored, with a grayish black ring around the middle and brown spots throughout, dripping water from corroded faucet. This eye wash station was located and used by both E and F halls. On 8/17/14 at 7:00 p.m., Licensed Practical Nurse #3 indicated the doors were supposed to be locked. At that time, he tried the door to the eye wash			

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	station and found that the lock would not "catch." He went into the station and tried the door from the inside, then indicated the door had been unlocked from the inside. He locked the door back up and indicated it was now locked from the hallway and a code was needed to enter the room. The Maintenance Director was contacted at that time and the lock to the soiled utility room was enabled. On 8/17/14 at 7:10 p.m., the Director of Nursing indicated both doors had been unlocked from the inside, and both doors should have been locked and opened from the hallway only after using a code. Documentation received from the Unit Manager of the A, B, and C halls, indicated there were 36 residents who were independently mobile on the unit. The most recent facility Minimum Data Set assessments indicated 16 of those 36 residents were cognitively impaired. Documentation received from the Director of Nursing on 8/22/14 at 10:25 a.m., indicated there were 13 residents on the E and F halls who were independently mobile. The most recent facility Minimum Data Set assessments indicated 3 of those 13 residents were cognitively			

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	impaired. 3.1-45(a)(1)			
F000329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on interview and record review, the failed to ensure adequate monitoring was completed for abnormal involuntary movements for 3 of 5 residents reviewed for unnecessary medications. (Resident #70, Resident #139, and Resident #11)	F000329	1.AIMS were completed for residents #70, #139, and#11 and any negative results were communicated to the attending physician. 2.All residents have the potential to be affectedby this	09/26/2014

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	Findings include: 1. The clinical record of Resident #70 was reviewed on 8/19/14 at 5:15 p.m. Diagnoses included, but were not limited to, depressive disorder, renal (kidney) failure, liver disorder, and gastroesophageal reflux (a condition in which the stomach contents leak backwards into the tube between the stomach and the mouth). A review of the recapitulation of physician's orders for August 2014, indicated Resident #70 was ordered metoclopram 5 mg (milligrams) (adverse reactions: ...extrapyramidal symptoms ... tardive dyskinesia/uncontrolled or involuntary movements) 3 times a day before meals as an appetite stimulant. The origination date of the metoclopram was 6/8/13. A review of the Medication Administration Record (MAR) for August 2014, indicated Resident #70 was administered metoclopram (Reglan) daily 3 times a day. A review of observation reports completed for Resident #70 indicated an Abnormal Involuntary Movement Scale (AIMS/an assessment to evaluate for		practice. All residents takingMetoclopram were reviewed for completed AIMS. AIMS were completed for all residents on Metoclopram that lacked them. 3.Licensed staff will be provided in-servicetraining by the Staff Development Coordinator regarding the need for AIMS onall residents taking Metoclopram (Reglan), and Compazine, just as they wouldany anti-psychotic medication by 9/26/14. All new orders will be reviewed daily at Morning Meeting for among otherthings, required AIMs. DNS / Designeewill assure that receiving ant-psychoticmedication will have an AIMS completed every 6 months with abnormal resultsreported to the attending Physician. 4.Completion of AIMS for appropriate medicationsincluding Metoclopram and Compazine will be monitored by PsychoactiveManagement CQI tool monthly at Quality Assurance Committee meeting for 6 monthsat 100% proficiency, then quarterly thereafter for 2 consecutive quarters. Issues identified by the Quality AssuranceCommittee will addressed by corrective action plan.	

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	155072	A. BUILDING 00 B. WING	08/27/2014

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	extrapyramidal symptoms and/or tardive dyskinesia) was completed 11/5/13. During an interview with the Director of Nursing (DON) on 8/22/14 at 10:30 a.m., the DON indicated the AIMS completed 11/5/13, was the most recent one for Resident #70. 2. The clinical record of Resident #139 was reviewed on 8/20/14 at 2:53 p.m. Diagnoses included, but were not limited to gastroparesis (a condition that occurs when the stomach takes too long to empty). A review of the recapitulation of physician's orders for August 2014, indicated Resident #139 was ordered metoclopram (Reglan) 10 mg (milligrams) (adverse reactions: ...extrapyramidal symptoms ... tardive dyskinesia/uncontrolled or involuntary movements) 3 times a day for gastroparesis. The origination date of the metoclopram was 4/19/14. A review of the Medication Administration Record (MAR) for August 2014, indicated Resident #139 was administered metoclopram daily 3 times a day. During a review of observation reports			

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	completed for Resident #139 no Abnormal Involuntary Movement Scale (AIMS/an assessment to evaluate for extrapyramidal symptoms and/or tardive dyskinesia) were found. During an interview with the Director of Nursing (DON) on 8/22/14 at 10:30 a.m., the DON indicated no AIMS had been completed for Resident #139. 3. The clinical record of Resident #11 was reviewed on 8/21/14 at 4:04 p.m. Diagnoses included, but were not limited to, restless leg syndrome, obsessive compulsive disorder, anxiety, depression, diabetes, and gastroparesis (a condition that occurs when the stomach takes too long to empty). A review of the recapitulation of physician's orders for August 2014, indicated Resident #11 was ordered metoclopram (Reglan) (adverse reactions: ...extrapyramidal symptoms ... tardive dyskinesia/uncontrolled or involuntary movements) 10 mg 4 times a day for diabetes. A review of the Medication Administration Record (MAR) for August 2014, indicated Resident #11 was administered metoclopram daily 4 times a day.			

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	During a review of observation reports completed for Resident #11 no Abnormal Involuntary Movement Scale (AIMS/an assessment to evaluate for extrapyramidal symptoms and/or tardive dyskinesia) were found. During an interview with the Director of Nursing (DON) on 8/21/14 at 3:30 p.m., the DON indicated Resident #11 was receiving Reglan and should have had an AIMS completed, but no AIMS had been completed for Resident #11. The DON provided the "Documentation Guidelines for Nursing" dated 6/2014, and indicated the policy was the one currently used by the facility. The policy indicated, "...Assessments completed - Other...AIMS - every 6 months for residents receiving antipsychotics or Reglan [metoclopram]...." The Nursing Drug Handbook, 34th edition, copy right 2014, indicated residents receiving metoclopram should be assessed and monitored for involuntary movements. 3.1-48(a)(4)			

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R000000	This state residential finding is cited in accordance with 410 IAC 16.2-5.	R000000		
R000349	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on interview and record review, the facility failed to ensure resident charts were complete and accurate for 1 of 7 residents' charts reviewed in that oxygen saturations and dialysis site checks were not documented completely. (Resident #6) Findings include: Resident #6's clinical record was reviewed on 8/25/14 at 11:15 a.m. Diagnoses included, but were not limited	R000349	1.Resident #6 O2 saturations were obtained byDNS. Resident #6 dialysis site waschecked per order by DNS. 2.All AL residents have the potential to beaffected by this practice. Residentswith orders for Oxygen had the O2 saturations checked by the DNS. Residents receiving dialysis had their siteschecked by DNS per physicians orders. 3.Staff received in-service training by the StaffDevelopment Coordinator / Designee regarding obtaining and documenting	09/26/2014

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	to, chronic obstructive pulmonary disorder (lung diseases that block airflow in the lungs and make it hard to breath) and chronic renal failure (inability of the kidneys to excrete body wastes) with dialysis (medical process to remove wastes from the body when the kidneys are unable to). 1. Recapulated Physician orders dated August 2014, indicated, "Check O2 [oxygen] Sats [level of oxygen in the body] every shift." The recapulated order indicated, oxygen saturation order was originally ordered on 4/21/14. Recapulated Physician orders dated August 2014, indicated, "O2 [oxygen] @ [at] 2l [liters] via nasal cannula for nocturnal use for Sats <90% [less than]." The recapulated order indicated, oxygen at 2L order was originally ordered on 4/21/14. No documentation of oxygen saturations for Resident #6 were found for April 2014, May 2014, nor the following shifts in July 2014: 7/4/14 night shift 7/13/14 day shift 7/14/14 night shift 7/15/14 night shift 7/21/14 night shift 7/22/14 night shift		O2saturations per physicians orders. Staffreceived in-service training by the Staff Development Coordinator / Designee onpost-dialysis protocols including following the physicians orders for dialysissite assessment and proper documentation. 4.Vital sign monitoring including properdocumentation with the MAR will be monitored via audits of the MAR by the DNS /Designee. The results of those auditswill be compiled and reported to the Quality Assurance Committee for 6 consecutivemonths with 95% proficiency and quarterly thereafter for 2 consecutivemonths. Dialysis site monitoring will becompleted via Dialysis Appointment Assessment form daily by the DNS /Designee. Results of those forms will becompiled and recorded on the Dialysis Care CQI monthly for review by theQuality Assurance Committee for 6 consecutive months with 90% proficiency thenquarterly thereafter for 2 consecutive quarters. Issues identified by the committee will beaddressed via Corrective Action Plan.	

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	7/22/14 day shift 7/24/14 day shift 7/25/14 night shift 7/26/14 night shift 7/27/14 night shift 7/28/14 day shift 7/29/14 night shift 7/29/14 day shift 7/30/14 day shift On 8/25/14 at 3:25 p.m., the Director of Nursing (DON) indicated, the facility was unable to locate oxygen saturations for April 2014, May 2014, nor the dates in question for July 2014. On 8/25/14 at 3:25 p.m., the DON provided the Oxygen Therapy policy, dated 4/2014, and indicated the policy was the one currently used by the facility. The policy indicated, "... 3. The nurse will coordinate the oxygen therapy services as ordered by the resident's physician...." 2. Recapulated physician orders dated August 2014, indicated, "Access site [area on the body used to implement dialysis] top left forearm, check dressing site daily." The recapulated orders indicated the original order date was 6/4/13. No documentation was found indicating			

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	Resident #6's dialysis site was checked daily for the following months: February 2014 March 2014 April 2014 May 2014 June 2014 July 2014 On 8/25/14 at 3:25 p.m., the DON indicated, The facility was unable to find documentation to indicated Resident #6's dialysis site was checked daily. The DON further indicated the residential facility did not have a policy to refer to for dialysis care.			